INTRACEPT™
Vertebrogenic Pain Relief

Boston Scientific
Advancing science for life™

Coverage Criteria Summary – Medical Mutual
Thermal Ablation of the Intraosseous Basivertebral Nerve (BVN)
Corporate Medical Policy

Medical Mutual has issued a coverage policy for the Intracept™ Procedure **effective 06/09/2026,** for commercial plans managed directly by Medical Mutual. Medicare Advantage and select commercial plans will continue to be managed by Cohere. For those plans, please refer to Cohere's checklist.

Medical Mutual's policy outlines specific details regarding criteria and limitations to meet medical necessity.

The requirements should be adhered to closely and documented accordingly in the patient chart to ensure the patient meets medical necessity.

Medical Necessity Criteria:

The Company considers thermal ablation of the basivertebral nerve to be medically necessary and eligible for reimbursement providing that all of the following medical necessity criteria are met:

- ☐ 1. Patient is skeletally mature (at least 18 years old); **AND**
- ☐ 2. Chronic lumbar back pain lasting at least 6 months that causes functional deficit measured on pain or disability scales; **AND**
- ☐ 3. Documentation of moderate to severe pain; **AND**
- ☐ 4. No significant improvement in pain or disability despite receiving non-surgical management interventions (i.e., physical therapy including home exercise program and anti-inflammatory medicals or oral steroids) for more than 6 weeks, unless medically contraindicated; **AND**
- ☐ 5. The patient has undergone screening, evaluation (including psychological), and diagnosis by multidisciplinary team; **AND**
- ☐ 6. MRI indicates Modic change in one or more vertebrae from L3 to S1, as shown by either of the following:
  - Inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, or hypointense signals (Type 1); or
  - Changes to vertebral body marrow, including replacement of normal bone marrow by fat or hyperintense signals (Type 2).

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Limitations:

- One basivertebral nerve per vertebral body (from L3 to S1) may be treated per lifetime.
- Up to 4 vertebral bodies may be treated during a single procedure.

Thermal ablation of the basivertebral nerve is **not** considered appropriate if **any** of the following criteria are met:

- Severe cardiac or pulmonary compromise; or
- Active systemic or local infection at the intended treatment level; or
- Bleeding diathesis; or
- Pregnancy; or
- Leg pain or numbness that occurs with walking (neurogenic claudication), severe pain that radiates from the back into the hip and outer side of the leg (lumbar radiculopathy), or radicular pain due to pinched nerve(s) (neurocompression [e.g., herniated nucleus pulposus, stenosis]), or posterior spinal column pain as primary symptoms; or
- Primary radicular pain into the lower extremities (defined as nerve pain following dermatomal distribution and that correlates with nerve compression on imaging); or
- Previous lumbar or lumbosacral spine surgery at intended treatment level (with the exception of discectomy/laminectomy if performed greater than 6 months prior to basivertebral nerve ablation and radicular pain resolved); or
- Primary symptomatic lumbar or lumbosacral spinal stenosis (defined as the presence of neurogenic claudication and confirmed by imaging); or
- Diagnosed osteoporosis (T-score of -2.5 or less); or
- Spine fragility fracture history; or
- Trauma or compression fracture at intended treatment level; or

• Spinal cancer; or

• MRI evidence of Modic changes, Type 1 or Type 2, at greater than three vertebral bodies; or

• Radiographic evidence that correlates with predominant physical complaints, as indicated by any of the following:

  - Lumbar or lumbosacral disc extrusion or protrusion greater than 5 mm at levels L3 to S1; or
  - Lumbar or lumbosacral spondylolisthesis of at least 2 mm at any level; or
  - Lumbar or lumbosacral spondylolysis at levels L3 to S1; or
  - Lumbar or lumbosacral facet arthrosis or effusion correlated with facet-mediated pain at levels L3 to S1; or

- Evidence on an imaging study (MRI) suggesting another obvious cause for low back pain, including but not limited to any of the following:
  - Lumbar stenosis; or
  - Facet arthropathy; or
  - Nerve root compression; or
  - Free fragment disc extrusion; or
  - Disc protrusion greater than 5 mm; or
  - Disc height loss greater than 50% compared to normal levels on the same study; or

- Other obvious etiology of low back pain on imaging); or

• Patient with BMI greater than 40 kg/m2; or
• Advanced generalized systemic disease that limits quality-of-life improvements (without statement of objective of treatment); or
• Active untreated substance abuse disorder; or
• Patient is being treated with radiation, chemotherapy, immunosuppression, or chronic steroid therapy (prednisone use up to 5 mg once daily or its equivalent is allowed); or
• Patient is taking extended-release narcotics (e.g., Fentanyl Patch, MSContin, Oxycontin); or
• Presence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorder (e.g., fibromyalgia); or
• Implantable pulse generator (e.g., pacemakers, defibrillators) or other electronic implants unless specific precautions are taken to maintain patient safety; or
• Beck Depression Inventory greater than 24; or
• Non-vertebrogenic pathology that could explain source of patient's pain (e.g., fracture, tumor, infection, stenosis, facet mediated pain, significant deformity), as indicated by any of the following:

- Clinical assessment; or
- Imaging study

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Coding:

CPT Code	Description
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first two vertebral bodies lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral

References:

https://www.medmutual.com/-/media/MedMutual/Files/Providers/CorporateMedicalPolicies/202605-Intraosseous-Basivertebral-Nerve-Ablation.pdf

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View Boston Scientific Intracept Intraosseous Nerve Ablation System Indications, Safety, and Warnings at bostonscientific.com/intracept-indications

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